

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG222 11-4-57 et

CERTIFICATE OF DEATH

10440

10440 51

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Republic Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u>	
c. LENGTH OF STAY IN 1b <u>4 mos.</u>		d. STREET ADDRESS <u>3 Deepdene Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elva Meredith Anderson</u>		4. DATE OF DEATH <u>Oct. 24 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 28, 1868</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 MRS. Months Days Hours Min. <u>9 26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Whitehall, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel H. Meredith</u>		14. MOTHER'S MAIDEN NAME <u>Clarinda Fredway</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Mrs. Mayfield Gray, Port Republic Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 19, 1957</u> to <u>Oct 24, 1957</u> , that I last saw the deceased alive on <u>Oct 24, 1957</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Devillarre</u> M.D.		DATE SIGNED <u>10/24</u>	
PHYSICIAN'S NAME (Type) <u>R. DEVILLARRE</u>		M.D. <u>K.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 26, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Madonna, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. G. Harkness & Son, Mutual, Md.</u>		ADDRESS <u>10-25-57</u>	
24a. REC'D BY REGISTRAR <u>N. W. Ward</u>		DATE <u>10-25-57</u>	

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10441

Items 11, 12 Film G222 11-5-57 et

CERTIFICATE OF DEATH

10441

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelina	
c. LENGTH OF STAY IN 1b 25 hrs.		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Co., Hospital	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Co., Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Brooks Last		4. DATE OF DEATH Month 10 Day 28 Year 1957	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mrs. 14 1895
9. AGE (In years last birthday) yrs. 62		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) B.A.B. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Height		14. MOTHER'S MAIDEN NAME Caroline Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Lillian Brooks Parran		Address 56 Seton Pl. N.W. Wash. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Acidosis 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes DUE TO (c) Uremic Toxemia Infection		INTERVAL BETWEEN ONSET AND DEATH 10/26/57 10/23/57	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 27, 1957 , to Oct 28, 1957 , that I last saw the deceased alive on Oct 27, 1957 , and that death occurred at 1 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Page Jett		ADDRESS (Street, city or town, state) Prince Frederick	
PHYSICIAN'S NAME (Type) Dr. Page Jett		DATE SIGNED 10/24/57	
22a. BURIAL CREMATION, REMOVAL (Specify) 10-30-57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Carrolls		22d. LOCATION (City, town, or county) (State) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE P. E. Sewell, Prince Fred, Md		ADDRESS	
24a. REC'D BY REGISTRAR 10-31-57		24b. REGISTRAR'S SIGNATURE H. W. Ward	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1932		MEMPHIS, TENN.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION	
APRIL 4, 1968		MEMPHIS, TENN.		SHOOTING		SUICIDE		ATTORNEY		HIGH SCHOOL	
TIME OF DEATH		HOURS		MINUTES		TEMPERATURE		PULSE		BLOOD PRESSURE	
10:00 PM		10		00		100.0		60		120/80	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10442

CERTIFICATE OF DEATH

Reg. Dist. No. 51

10442

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Prince Frederick</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Swings</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert Co. Hospital</u>				STREET ADDRESS (If rural give location) <u>Prince Frederick md</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>John</u>		(Middle) <u>D.</u>		(Last) <u>Brown</u>		(Month) <u>10</u> (Day) <u>11</u> (Year) <u>1957</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Unknown</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Brown</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Gull</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr Edith Thompson 1102 Vermont ave</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
442X IMMEDIATE CAUSE (A) <u>Hypertension C.V.R. disease</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/2</u> , 19 <u>51</u> , to <u>10/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/10</u> , 19 <u>57</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		DATE THEREOF <u>10-13-57</u>		NAME OF CEMETERY OR CREMATORY <u>Phon Point</u>		LOCATION (City, town, or county) (State) <u>Calvert Co. md</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		24. REC'D BY REGISTRAR DATE <u>10-11-57</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u>		ADDRESS <u>Prince Frederick md</u>	

10443

CERTIFICATE OF DEATH

Reg. Dist. No.

51

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lesley</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Lesley</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>M.</u> Last <u>Claquet</u>				4. DATE OF DEATH Month <u>10</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 57</u>	9. AGE (In years lost birthday) yrs. <u>3</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Warren Claquet</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Janey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Catherine Janey, Lesley, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia (lobar)</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-26</u> , 19 <u>57</u> , to <u>10-30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-23</u> , 19 <u>57</u> , and that death occurred at <u>3:30</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. E. Villard</u> M.D.				ADDRESS (Street, city or town, state) <u>St. Bernard</u>		DATE SIGNED <u>10/30</u>	
PHYSICIAN'S NAME (Type) <u>R. E. VILLARREAL - St. Bernard</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-1, 57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Brooks</u>		22d. LOCATION (City, town, or county) (State) <u>Island Creek, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. J. Seavey, Prince Fred, Md</u>				ADDRESS <u>11/5/57</u>		24a. REC'D BY REGISTRAR <u>H. H. Hardy</u>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. S.

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10444

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Was deceased lived. If Institution, residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dwight</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>Dwight</i> <i>x0</i>	
3. NAME OF DECEASED (Type or print) <i>William</i> First <i>Clayton</i> Middle <i>Clayton</i> Last		4. DATE OF DEATH Month <i>10</i> Day <i>7</i> Year <i>19-57</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month <i>March</i> Day <i>22</i> Year <i>1910</i>
9. AGE (In years last birthday) <i>57</i> yrs.		IF UNDER 1 YEAR Months <i>57</i> Days <i>57</i>	IF UNDER 24 HRS. Hours <i>57</i> Min. <i>57</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Auto Driver</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Landscaper</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>John Clayton</i>		14. MOTHER'S MAIDEN NAME <i>Madora Jefferson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>James Clayton</i> Address <i>Dwight Md</i>			
18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <i>420.1</i> DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Went to work felt badly and died at home</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <i>10/7/57</i> Hour <i>11</i> o. m. <i>10/7</i> 1957		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Dwight Calvert Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H W Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Oct 10-57</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>St Edmonds</i>		22d. LOCATION (City, town, or county) <i>Calvert Md</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P.E. Sewell, Jr., Fred Md</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>10/10/57</i>		DATE	
24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CLERGY		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF BURIAL		21. SIGNATURE OF CREMATION	
22. SIGNATURE OF INTERMENT		23. SIGNATURE OF REINTERMENT		24. SIGNATURE OF REINTERMENT	
25. SIGNATURE OF REINTERMENT		26. SIGNATURE OF REINTERMENT		27. SIGNATURE OF REINTERMENT	
28. SIGNATURE OF REINTERMENT		29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT	
31. SIGNATURE OF REINTERMENT		32. SIGNATURE OF REINTERMENT		33. SIGNATURE OF REINTERMENT	
34. SIGNATURE OF REINTERMENT		35. SIGNATURE OF REINTERMENT		36. SIGNATURE OF REINTERMENT	
37. SIGNATURE OF REINTERMENT		38. SIGNATURE OF REINTERMENT		39. SIGNATURE OF REINTERMENT	
40. SIGNATURE OF REINTERMENT		41. SIGNATURE OF REINTERMENT		42. SIGNATURE OF REINTERMENT	
43. SIGNATURE OF REINTERMENT		44. SIGNATURE OF REINTERMENT		45. SIGNATURE OF REINTERMENT	
46. SIGNATURE OF REINTERMENT		47. SIGNATURE OF REINTERMENT		48. SIGNATURE OF REINTERMENT	
49. SIGNATURE OF REINTERMENT		50. SIGNATURE OF REINTERMENT		51. SIGNATURE OF REINTERMENT	
52. SIGNATURE OF REINTERMENT		53. SIGNATURE OF REINTERMENT		54. SIGNATURE OF REINTERMENT	
55. SIGNATURE OF REINTERMENT		56. SIGNATURE OF REINTERMENT		57. SIGNATURE OF REINTERMENT	
58. SIGNATURE OF REINTERMENT		59. SIGNATURE OF REINTERMENT		60. SIGNATURE OF REINTERMENT	
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64. SIGNATURE OF REINTERMENT		65. SIGNATURE OF REINTERMENT		66. SIGNATURE OF REINTERMENT	
67. SIGNATURE OF REINTERMENT		68. SIGNATURE OF REINTERMENT		69. SIGNATURE OF REINTERMENT	
70. SIGNATURE OF REINTERMENT		71. SIGNATURE OF REINTERMENT		72. SIGNATURE OF REINTERMENT	
73. SIGNATURE OF REINTERMENT		74. SIGNATURE OF REINTERMENT		75. SIGNATURE OF REINTERMENT	
76. SIGNATURE OF REINTERMENT		77. SIGNATURE OF REINTERMENT		78. SIGNATURE OF REINTERMENT	
79. SIGNATURE OF REINTERMENT		80. SIGNATURE OF REINTERMENT		81. SIGNATURE OF REINTERMENT	
82. SIGNATURE OF REINTERMENT		83. SIGNATURE OF REINTERMENT		84. SIGNATURE OF REINTERMENT	
85. SIGNATURE OF REINTERMENT		86. SIGNATURE OF REINTERMENT		87. SIGNATURE OF REINTERMENT	
88. SIGNATURE OF REINTERMENT		89. SIGNATURE OF REINTERMENT		90. SIGNATURE OF REINTERMENT	
91. SIGNATURE OF REINTERMENT		92. SIGNATURE OF REINTERMENT		93. SIGNATURE OF REINTERMENT	
94. SIGNATURE OF REINTERMENT		95. SIGNATURE OF REINTERMENT		96. SIGNATURE OF REINTERMENT	
97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT		99. SIGNATURE OF REINTERMENT	
100. SIGNATURE OF REINTERMENT		101. SIGNATURE OF REINTERMENT		102. SIGNATURE OF REINTERMENT	

BUREAU V. S.

OCT 15 1957

RECEIVED

10445

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cabot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>1 yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> 47X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabot County Hosp. Anne</u>				d. STREET ADDRESS <u>1364 Quincy St., N.W.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CORA MADDOX COLE</u>				4. DATE OF DEATH Month Day Year <u>Oct. 25, 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 11, 1864</u>	9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Leonardtown, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George T. Maddox</u>				14. MOTHER'S MAIDEN NAME <u>Susan Ruth Harris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>3</u>		17. INFORMANT Address <u>Hospital Records - Prince Frederick, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyper Resp Inf. Pharyngitis</u> <u>903.7</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fractured Hip</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Oct</u> <u>Sept 29</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in own Room in Hospital</u>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Cabot Nursing Prince Frederick</u>				20f. (City or town) (County) (State) <u>Cabot Md</u>			
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>56</u> , to <u>Oct 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 24</u> , 19 <u>57</u> , and that death occurred at <u>11 a</u> . M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Page Jett</u> M.D. <u>Prince Frederick</u> <u>10/25/57</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>PAGE C. JETT M.D. PRINCE FREDERICK</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 28, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.D. Harkness & Son - Mutual, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>10/24/57</u>		24b. REGISTRAR'S SIGNATURE <u>N.W. Ward</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10446

10446

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabret</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cabret</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntington</u>	
c. LENGTH OF STAY IN 1b <u>4 mo</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabret County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BESSIE</u> First Middle Last <u>COX</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1878</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR <u>5</u> Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Cabret Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Crawford</u>		14. MOTHER'S MAIDEN NAME <u>Cassandra Halsey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs Yenta Turner</u> Address <u>Sunderland Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Secondary Metastasis to Liver</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>1 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March, 1956</u> to <u>Oct. 16, 1957</u> , that I last saw the deceased alive on <u>Oct. 16, 1957</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Page Jett</u> M.D. <u>PRINCE FREDERICK</u>		DATE SIGNED <u>10/18/57</u>	
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 18, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Emanuel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Phon Point - Cabret Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Q. Harkness & Son</u> ADDRESS <u>Mutual, Md.</u>		24a. REC'D BY REGISTRAR <u>H. W. Ward</u> DATE <u>10-18-57</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH	
6. PLACE OF DEATH		7. CITY		8. COUNTY		9. STATE		10. ZIP CODE	
11. OCCUPATION		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. PLACE OF BIRTH		15. DATE OF BIRTH	
16. NAME OF PHYSICIAN		17. NAME OF HOSPITAL		18. NAME OF NURSE		19. NAME OF CORONER		20. NAME OF MINISTER	
21. NAME OF FUNERAL HOME		22. NAME OF BURIAL PLACE		23. NAME OF CEMETERY		24. NAME OF INTERMENT		25. NAME OF CREMATION	
26. NAME OF NEXT OF KIN		27. NAME OF SURVIVOR		28. NAME OF WITNESS		29. NAME OF JURY		30. NAME OF JUDGE	
31. NAME OF CLERK		32. NAME OF REGISTRAR		33. NAME OF ASSISTANT		34. NAME OF CLERK		35. NAME OF REGISTRAR	
36. NAME OF ASSISTANT		37. NAME OF CLERK		38. NAME OF REGISTRAR		39. NAME OF ASSISTANT		40. NAME OF CLERK	
41. NAME OF REGISTRAR		42. NAME OF ASSISTANT		43. NAME OF CLERK		44. NAME OF REGISTRAR		45. NAME OF ASSISTANT	
46. NAME OF CLERK		47. NAME OF REGISTRAR		48. NAME OF ASSISTANT		49. NAME OF CLERK		50. NAME OF REGISTRAR	
51. NAME OF ASSISTANT		52. NAME OF CLERK		53. NAME OF REGISTRAR		54. NAME OF ASSISTANT		55. NAME OF CLERK	
56. NAME OF REGISTRAR		57. NAME OF ASSISTANT		58. NAME OF CLERK		59. NAME OF REGISTRAR		60. NAME OF ASSISTANT	
61. NAME OF CLERK		62. NAME OF REGISTRAR		63. NAME OF ASSISTANT		64. NAME OF CLERK		65. NAME OF REGISTRAR	
66. NAME OF ASSISTANT		67. NAME OF CLERK		68. NAME OF REGISTRAR		69. NAME OF ASSISTANT		70. NAME OF CLERK	
71. NAME OF REGISTRAR		72. NAME OF ASSISTANT		73. NAME OF CLERK		74. NAME OF REGISTRAR		75. NAME OF ASSISTANT	
76. NAME OF CLERK		77. NAME OF REGISTRAR		78. NAME OF ASSISTANT		79. NAME OF CLERK		80. NAME OF REGISTRAR	
81. NAME OF ASSISTANT		82. NAME OF CLERK		83. NAME OF REGISTRAR		84. NAME OF ASSISTANT		85. NAME OF CLERK	
86. NAME OF REGISTRAR		87. NAME OF ASSISTANT		88. NAME OF CLERK		89. NAME OF REGISTRAR		90. NAME OF ASSISTANT	
91. NAME OF CLERK		92. NAME OF REGISTRAR		93. NAME OF ASSISTANT		94. NAME OF CLERK		95. NAME OF REGISTRAR	
96. NAME OF ASSISTANT		97. NAME OF CLERK		98. NAME OF REGISTRAR		99. NAME OF ASSISTANT		100. NAME OF CLERK	

BUREAU V. S.

OCT 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10447

CERTIFICATE OF DEATH

Reg. Dist. No. 10447

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) Calvert County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Richard Last Cox Sr.				4. DATE OF DEATH Month 10 Day 20 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-8-30	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James N. Cox				14. MOTHER'S MAIDEN NAME Mary Ellen Gibson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-36-3992		17. INFORMANT Address Mrs. Daisy Cox, Prince Frederick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181x DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ca of Bladder DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct 20, 1957 , to Oct 20, 1957 , that I last saw the deceased alive on Oct 20, 1957 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature] M.D.				ADDRESS (Street, city or town, state) 5 + Leonard			
PHYSICIAN'S NAME (Type) R. DE VILLIERS REED				DATE SIGNED 10/20			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 22, 1957		22c. NAME OF CEMETERY OR CREMATORY Central Methodist Cem		22d. LOCATION (City, town, or county) (State) Barstow - Calvert Co - Md	
23. FUNERAL DIRECTOR'S SIGNATURE A. A. Harkness & Son - Mutual, Md				24a. REC'D BY REGISTRAR DATE 10-23-57		24b. REGISTRAR'S SIGNATURE H. W. Ward	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 24 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10448

10448

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cabot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 Dunkirk</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabot County Hospital</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>C.</u> Middle <u>ORVILLE</u> Last <u>DRURY</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 26, 1883</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Cabot Co., Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>John H. Drury</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Carcand</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Ed. H. Roland Drury - Dunkirk, Ind.</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>				
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>
21. I certify that I attended the deceased from <u>20 Sept</u> , 19 <u>57</u> , to <u>5 Oct</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5 Oct</u> , 19 <u>57</u> , and that death occurred at <u>10:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. J. Weems</u>				ADDRESS (Street, city or town, state) <u>Huntingtown Md</u>		DATE SIGNED <u>6 Oct 57</u>	
PHYSICIAN'S NAME (Type) <u>G. J. WEEMS</u>				ADDRESS <u>HUNTINGTOWN, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 8, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shiloh Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dunkirk Cabot Co., Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Hackness & Son - Mutual, Ind.</u>				24a. REC'D BY REGISTRAR DATE <u>10/7/57</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

BUREAU V. 5

OCT 9 1957

RECEIVED

10449

CERTIFICATE OF DEATH

10449

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM PYLES FINK</u>				4. DATE OF DEATH Month Day Year <u>Oct 19, 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 26 1880</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Jacob Fink</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>760.</u>		17. INFORMANT <u>Lena Fink - Huntingtown Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ART. SCL C.V. DISEASE</u> DUE TO (c) <u>PROSTATISM</u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>PHILIP JETT</u>				ADDRESS (Street, city or town, state) <u>Prince Frederick Md.</u>			
PHYSICIAN'S NAME (Type) <u>PHILIP JETT</u>				DATE SIGNED <u>10/19/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Beltsville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Maryland</u>		24a. REC'D BY REGISTRAR <u>OCT 23 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Fugh Hardy</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10450

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cabaret</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Breezy Point</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>04X21</u>	
3. NAME OF DECEASED (Type or print) First <u>AUGUSTINE</u> Middle <u>H.</u> Last <u>GERARD</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 18, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>France</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Humbert</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Andre E. Gerard Sr. Clinton, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic C.V. disease</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Oct 2</u> , 19 <u>57</u> , to <u>Oct 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 2</u> , 19 <u>57</u> , and that death occurred at <u>3P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Page Jett</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Prince Frederick 10/4/57</u>	
PHYSICIAN'S NAME (Type) <u>PAUL C. JETT M.D.</u>		<u>PRINCE FREDERICK MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Cremation</u>	<u>Oct. 5, 1957</u>	<u>Lee's</u>	<u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
<u>See Funeral Home Washington - D.C.</u>		<u>10/9/57</u>	<u>A.W. Ward</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 9 1957

RECEIVED

10451

CERTIFICATE OF DEATH

Reg. Dist. No.

51

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Chesapeake</u> <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Gross</u> Last <u>Gross</u>				4. DATE OF DEATH Month <u>10</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15</u>		9. AGE (In years last birthday) <u>71</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Samuel Gross</u>				14. MOTHER'S MAIDEN NAME <u>Mariah Lake</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mervin Gross, Chesapeake, Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alan Mammie</u> <u>480x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>flu</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 wk</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had been sick for a week</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>4:30</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chesapeake, Md</u> DATE SIGNED <u>H. W. Ward</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>10-29-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Edwards</u>	
22d. LOCATION (City, town, or county) <u>Calvert, Md.</u>				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u> ADDRESS <u>Prince Fred, Md</u>				24a. REC'D BY REGISTRAR <u>10-31-57</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

RECEIVED
NOV 1 1957
BUREAU V. S.

RECEIVED
NOV 1 1957
BUREAU V. S.

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY	
COUNTY		STATE	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIAGE		MILITARY SERVICE	
PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		SIGNATURE OF PHYSICIAN	
SIGNATURE OF REGISTRAR		DATE OF REGISTRATION	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 221 10-11-57 et

CERTIFICATE OF DEATH

10452

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>				c. LENGTH OF STAY IN 1b <i>5 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Calvert County Hospital</i>				d. STREET ADDRESS <i>Benedict 08 X 0.2</i>			
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>J.</i> Last <i>Higgs</i>				4. DATE OF DEATH Month <i>10</i> Day <i>7</i> Year <i>19 57</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11/6/1884</i>	
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steel</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Steel Worker</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Alfred Higgs</i>				14. MOTHER'S MAIDEN NAME <i>Mary Farrell</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give year or dates of service) <i>No</i> <i>No</i>				16. SOCIAL SECURITY NO. <i>191-03-6424</i>			
17. INFORMANT <i>Mary Higgs</i>				Address <i>Benedict md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> <i>540.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Ruptured gastric ulcer</i> DUE TO (c) <i>Coronary Arteriosclerosis</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Oct 3, 1957</i> to <i>Oct 7, 1957</i> , that I last saw the deceased alive on <i>Oct 3, 1957</i> , and that death occurred at <i>10</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>R de Villarreal</i> M.D.				ADDRESS (Street, city or town, state) <i>St Bernard</i> DATE SIGNED <i>at 7/1</i>			
PHYSICIAN'S NAME (Type) <i>R de VILLARREAL MD</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>Oct. 7, 1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Bernard</i>		22d. LOCATION (City, town, or county) (State) <i>Duquesne - Pa</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G.A. Barkness & Son</i>				ADDRESS <i>mutual, Ind</i>		24a. REC'D BY REGISTRAR DATE <i>10/8/57</i>	
				24b. REGISTRAR'S SIGNATURE <i>N.W. Ward</i>			

BUREAU V. S.

OCT 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10453

Reg. Dist. No. 51

10453

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderland</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderland</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wilmer</u> First <u>Holland</u> Middle <u>Holland</u> Last		4. DATE OF DEATH <u>10/3</u> Month <u>10</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 17</u>
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Henry Holland</u>		14. MOTHER'S MAIDEN NAME <u>Rhena Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Henry Holland</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation due to</u> <u>974X</u> DUE TO <u>self-inflicted hanging</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u>Suicide</u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found hanging in Barn</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter notice of injury in Part I or Part II of item 18.) <u>Strangulation</u>	
20c. TIME OF INJURY Month, Day, Year <u>10/3/57</u> Hour <u>6:30</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Sunderland</u> (County) <u>Calvert</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. W. Ward</u>		DATE SIGNED <u>10/3/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>10-7-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Edmonds</u>		22d. LOCATION (City, town, or county) <u>Sunderland</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Jewell</u> ADDRESS <u>Pr. Frederick, Md</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>10/8/57</u>	
24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
OCT 9 1957
BUREAU V. S.

1 **INSTRUCTIONS** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10454

CERTIFICATE OF DEATH

10454

Reg. Dist. No. 52

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sunderland</u>		LENGTH OF STAY (in this place) <u>50 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sunderland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>WILLIAM</u> <u>HENRY</u> <u>Ireland</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct</u> <u>23</u> <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Aug. 18, 1869</u>		9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm - owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Clay Ireland</u>				14. MOTHER'S MAIDEN NAME <u>Louise Birkhead</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>John B. Ireland, Sunderland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/10</u> , 19 <u>49</u> , to <u>10/23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/23</u> , 19 <u>57</u> , and that death occurred at <u>5 A.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D. <u>Huntingtown Md</u>				DATE SIGNED <u>10/24/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 25, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Smithville Cemetery</u>		LOCATION (City, town, or county) <u>Dunkirk, Maryland</u>	
24. REC'D BY REGISTRAR <u>10/24/57</u>		REGISTRAR'S SIGNATURE <u>Grace L. Hutchins</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Owings, Md.</u>			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10455

CERTIFICATE OF DEATH

10455
3/

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. LENGTH OF STAY IN 1b 14 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Co., Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Jackson Last				4. DATE OF DEATH Month 10 Day 12 Year 1957			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14 1875	9. AGE (In years birth day) yrs. 79	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Mayland		11. BIRTHPLACE (State or foreign country) U. S. A.	
13. FATHER'S NAME William Jackson				14. MOTHER'S MAIDEN NAME Chaney Gantt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Wife Mamie Jackson Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic - 592X DUE TO Chronic nephritis Enlargement Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) of prostate DUE TO (c) of prostate						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1957 to Oct 12, 1957 , that I last saw the deceased alive on Oct 12, 1957 , and that death occurred at 11:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Roberto De Villarreal				ADDRESS (Street, city or town, state) 5 S. Chennard, 1914 DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 10-17-57		22c. NAME OF CEMETERY OR CREMATORY Brook		22d. LOCATION (City, town, or county) (State) Island Creek, Md	
23. FUNERAL DIRECTOR'S SIGNATURE P. E. Sawell ADDRESS Prince Frederick, Md.				24a. REC'D BY REGISTRAR DATE 10-12-57		24b. REGISTRAR'S SIGNATURE A. W. Ward	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH			
JAMES EARL RAY		35		M		W		1922		MEMPHIS, TENN.		MEMPHIS, TENN.		TENNESSEE		UNITED STATES OF AMERICA			
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
OCT 6 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		TENNESSEE		UNITED STATES OF AMERICA		OCT 6 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		TENNESSEE		UNITED STATES OF AMERICA	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED	
HEART DISEASE		SUICIDE		LABORER		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
OCT 6 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		TENNESSEE		UNITED STATES OF AMERICA		OCT 6 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		TENNESSEE		UNITED STATES OF AMERICA	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED	
HEART DISEASE		SUICIDE		LABORER		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	

BUREAU V. S.

OCT 21 1957

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10456

CERTIFICATE OF DEATH

Reg. Dist. No. 51

10456

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dwight</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dwight</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Enoch</u> <u>Jones</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>10</u> <u>12</u> <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Jan. 3, 1910</u>	9. AGE last birthday <u>47</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Phillip Jones</u>				14. MOTHER'S MAIDEN NAME <u>Victoria Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>William Emerson, Dwight Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cardio vascular renal drain</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>hypertension</u>				<u>3 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Low mentality</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 8</u> , 19 <u>57</u> , to <u>Oct 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 9</u> , 19 <u>57</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>H. W. Ward</u>		ADDRESS (Street, city, town, state) <u>Dwight Md</u>		DATE SIGNED <u>10/14/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>10-10-57</u>		NAME OF CEMETERY OR CREMATORY <u>mt. hope</u>		LOCATION (City, town, or county) (State) <u>Sunderland Md</u>	
24. REC'D BY REGISTRAR DATE <u>10-12-57</u>		REGISTRAR'S SIGNATURE <u>H. W. Ward</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u>		ADDRESS <u>Pr. Fred. Ind.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10457

10457

CERTIFICATE OF DEATH

Reg. Dist. No.

51

1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick c. LENGTH OF STAY IN 1b St. Leonard x 2 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Leonard x 2 d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Eleck First H. Middle Parker Last				4. DATE OF DEATH Oct. 21 Month 1957 Day 1957 Year											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 23, 1890		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Bus Driver				10b. KIND OF BUSINESS OR INDUSTRY School Bus				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME John Parker				14. MOTHER'S MAIDEN NAME Edith Lloyd											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO. 128-01-6201				17. INFORMANT Mrs. Hazel Parker Address St. Leonard, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct 18 , 19 57 , to Oct 21 , 19 57 , that I last saw the deceased alive on Oct 21 , 19 57 , and that death occurred at 7:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) St Leonard, Md DATE SIGNED 10/22 ACTUAL SIGNATURE R. E. Viccarone M.D. R. E. VICCARONE PHYSICIAN'S NAME (Type) R. E. VICCARONE, ST LEONARD, MD															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Oct. 24, 1957		22c. NAME OF CEMETERY OR CREMATORY St Paul's M.E. Cem		22d. LOCATION (City, town, or county) (State) Bushy - Calvert Co. - Md							
23. FUNERAL DIRECTOR'S SIGNATURE A. O. Harkness & Son - Mutual, Md ADDRESS						24a. REC'D BY REGISTRAR DATE 10/24/57		24b. REGISTRAR'S SIGNATURE R. W. Ward							

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
John Barker		45		Male		White		1870		Boston, Mass.		Boston, Mass.		United States	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
100 North Street		Carpenter		Heart Disease		Natural		Oct 25, 1957		Boston, Mass.		Boston, Mass.		United States	
Physician's Signature		Physician's Name		Physician's Address		Physician's City		Physician's State		Physician's Country		Physician's Zip		Physician's Title	
[Signature]		Dr. J. H. Smith		100 North Street		Boston, Mass.		Mass.		U.S.A.		02101		M.D.	
Coroner's Signature		Coroner's Name		Coroner's Address		Coroner's City		Coroner's State		Coroner's Country		Coroner's Zip		Coroner's Title	
[Signature]		Mr. J. H. Smith		100 North Street		Boston, Mass.		Mass.		U.S.A.		02101		M.D.	
Registrar's Signature		Registrar's Name		Registrar's Address		Registrar's City		Registrar's State		Registrar's Country		Registrar's Zip		Registrar's Title	
[Signature]		Mr. J. H. Smith		100 North Street		Boston, Mass.		Mass.		U.S.A.		02101		M.D.	

BUREAU V. 3

OCT 25 1957

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10458

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH COUNTY <u>Calvert</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lusby</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Reimann</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Calvert</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lusby</u> STREET ADDRESS <u>1</u> (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Reimann</u> (First) <u>Smith</u> (Middle) <u>S</u> (Last)		4. DATE OF DEATH (Month) <u>10</u> (Day) <u>22</u> (Year) <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Aug. 16,</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>64</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mary Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>750A</u>	
17. INFORMANT & ADDRESS <u>Ms. North Smith, Lusby, Md</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>442X</u> IMMEDIATE CAUSE (A) <u>Septicemia C & R disease</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/1</u> , 19 <u>49</u> , to <u>10/22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/1</u> , 19 <u>57</u> , and that death occurred at <u>7:50 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>W. E. Searwell</u>		DATE SIGNED <u>10/23/57</u>	
ADDRESS (Street, city, town, state) <u>St Johns</u>			
M.D. <u>W. E. Searwell</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR	
DATE THEREOF <u>10-24-57</u>		REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	
NAME OF CEMETERY OR CREMATORY <u>St Johns</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Searwell</u>	
LOCATION (City, town, or county) <u>Lusby, Md</u>		ADDRESS <u>Prince Fred, Md</u>	
DATE <u>10-25-57</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

Form No. 1

1. NAME OF DECEASED (PRINT OR TYPE)

MARYLAND

COUNTY OF

CITY OF

STATE OF

DATE OF

TIME OF

PLACE OF

CAUSE OF

DATE OF

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NOTIFICATION

1. I hereby certify that the above is a true and correct statement of the facts as they appear to me, and that I am a duly qualified medical officer of health for the county of _____, State of _____, and that I am duly qualified to issue this certificate.

2. I hereby certify that the above is a true and correct statement of the facts as they appear to me, and that I am a duly qualified medical officer of health for the county of _____, State of _____, and that I am duly qualified to issue this certificate.

3. I hereby certify that the above is a true and correct statement of the facts as they appear to me, and that I am a duly qualified medical officer of health for the county of _____, State of _____, and that I am duly qualified to issue this certificate.

4. I hereby certify that the above is a true and correct statement of the facts as they appear to me, and that I am a duly qualified medical officer of health for the county of _____, State of _____, and that I am duly qualified to issue this certificate.

5. I hereby certify that the above is a true and correct statement of the facts as they appear to me, and that I am a duly qualified medical officer of health for the county of _____, State of _____, and that I am duly qualified to issue this certificate.

6. I hereby certify that the above is a true and correct statement of the facts as they appear to me, and that I am a duly qualified medical officer of health for the county of _____, State of _____, and that I am duly qualified to issue this certificate.

7. I hereby certify that the above is a true and correct statement of the facts as they appear to me, and that I am a duly qualified medical officer of health for the county of _____, State of _____, and that I am duly qualified to issue this certificate.

8. I hereby certify that the above is a true and correct statement of the facts as they appear to me, and that I am a duly qualified medical officer of health for the county of _____, State of _____, and that I am duly qualified to issue this certificate.

9. I hereby certify that the above is a true and correct statement of the facts as they appear to me, and that I am a duly qualified medical officer of health for the county of _____, State of _____, and that I am duly qualified to issue this certificate.

10. I hereby certify that the above is a true and correct statement of the facts as they appear to me, and that I am a duly qualified medical officer of health for the county of _____, State of _____, and that I am duly qualified to issue this certificate.

BUREAU V. 3

OCT 28 1957

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may be obtained by the hospital, or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2 & 7, Film G222, 11/1/57 fcy

10459

CERTIFICATE OF DEATH

Reg. Dist. No.

10459

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 28			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private Home</u>				d. STREET ADDRESS <u>203 N. Beechwood Ave. Catonsville</u>			
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>F</u> Last <u>Soper</u>				4. DATE OF DEATH Month <u>October</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 3, 1872</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>23</u>		IF UNDER 24 MRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Calvert Co., Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph R. Gibson</u>				14. MOTHER'S MAIDEN NAME <u>Gennie Mary Shekella</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>Carroll Soper</u>				Address <u>Huntingtown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>Oct 12</u> , 19 <u>57</u> , to <u>Oct 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u></u> , 19 <u></u> , and that death occurred at <u></u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. E. Williams</u> M.D.				ADDRESS (Street, city or town, state) <u>St Thomas</u> DATE SIGNED <u>10/26</u>			
PHYSICIAN'S NAME (Type) <u>R. E. Williams</u>				<u>St Thomas</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 28, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Huntingtown Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harrison</u> ADDRESS <u>1501 Nuttall, Md.</u>				24a. REC'D BY REGISTRAR <u></u> DATE <u>10-28-57</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10460

10460

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b <u>4 1/2 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Calvert County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Watkins</u> Last <u>Watkins</u>				4. DATE OF DEATH Month <u>10</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-1-01</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Sherman Estep</u>				14. MOTHER'S MAIDEN NAME <u>Laura Estep</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Ethel Jones -</u> Address <u>Huntingtown, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive c.v.d.</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>57</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>Oct 2, 1957</u> , to <u>Oct 2, 1957</u> , that I last saw the deceased alive on <u>Oct 2, 1957</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. E. Sewell</u> M.D.				ADDRESS (Street, city or town, state) <u>St Leonard Md</u> DATE SIGNED <u>10/2</u>			
PHYSICIAN'S NAME (Type) <u>R. E. SEWELL M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>10-6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wmmy</u>		22d. LOCATION (City, town, or county) (State) <u>A.A. CO. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u> ADDRESS <u>Prince Fred.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>10/4/57</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 19

OCT 7 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10461

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10461

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Fredrick</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>Adelphi x 9</i>	
3. NAME OF DECEASED (Type or print) <i>James</i> First <i>Willet</i> Middle <i>La</i> Last		4. DATE OF DEATH Month <i>10</i> Day <i>1</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/24/45</i>
9. AGE (In years last birthday) <i>12</i> yrs.		IF UNDER 1 YEAR Months <i>12</i> Days <i>1</i> Hours <i>19</i> Min. <i>57</i>	IF UNDER 24 HRS. Months <i>12</i> Days <i>1</i> Hours <i>19</i> Min. <i>57</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Sold</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Rogers Willet</i>		14. MOTHER'S MAIDEN NAME <i>Georgia Green</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or both) <i>No</i>		16. SOCIAL SECURITY NO. <i>10461</i>	
17. INFORMANT <i>Hospital Records</i>		Address <i>Calvert</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>900.0 Ruptured spleen and liver</i> DUE TO (b) <i>Fall on concrete steps while</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>playing with a soccer ball</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Fell on steps playing soccer</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>4</i> o. m. <i>9/27</i> p. m. <i>1957</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <i>at work</i>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Calvert</i> (County) <i>Md</i> (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H.W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 10/1/57 DATE SIGNED	
EXAMINER'S NAME (Type) <i>H.W. Ward</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>10-5-57</i>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <i>Carrolls</i>	22d. LOCATION (City, town, or county) <i>Barstow, Md</i> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell</i>		ADDRESS <i>Prince Fredrick, Md</i>	
24a. REC'D BY REGISTRAR <i>10-4-57</i>		24b. REGISTRAR'S SIGNATURE <i>N. W. Ward</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for 7 days. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		MARRIAGE	
PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		SIGNATURE OF EXAMINER	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
TIME OF EXAMINATION		SIGNATURE OF WITNESS	
FAMILY HISTORY		SOCIAL HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATION	
PATHOLOGICAL FINDINGS		CLINICAL FINDINGS	
HISTORICAL FINDINGS		GENERAL FINDINGS	
SPECIFIC FINDINGS		CONCLUSIONS	
REMARKS		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
TIME OF SIGNATURE		SIGNATURE OF JURY	
FAMILY HISTORY		SOCIAL HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATION	
PATHOLOGICAL FINDINGS		CLINICAL FINDINGS	
HISTORICAL FINDINGS		GENERAL FINDINGS	
SPECIFIC FINDINGS		CONCLUSIONS	
REMARKS		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
TIME OF SIGNATURE		SIGNATURE OF JURY	

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OCT 7 1957

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

10462

Reg. Dist. No. 51

10462

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Adelina md</u>				TOWN <u>Adelina md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
1							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Rene</u>		(Middle) <u>V.</u>		(Last) <u>Willett</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. SINGLE/MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH <u>Nov. 17, 1958</u>	
9. AGE last birthday <u>58</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Months		Days		Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>John E Henson</u>				14. MOTHER'S MAIDEN NAME <u>Louise Eggin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Roger Willett Adelina md</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.2 IMMEDIATE CAUSE (A) <u>Chr myocarditis.</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/10</u> , 19 <u>56</u> , to <u>10/23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/23</u> , 19 <u>57</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>10/24/57</u>			
ADDRESS (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>10-25-57</u>		<u>Carroll</u>		<u>Berston</u>		<u>md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>10/25/57</u>		<u>H. W. Ward</u>		<u>P. Z. Sewell</u>		<u>Pr. Fred md.</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. DEATH CERTIFICATE NUMBER

2. SEX

3. AGE

4. PLACE OF DEATH

5. DATE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. PLACE OF DEATH

12. DATE OF DEATH

13. PLACE OF BIRTH

14. DATE OF BIRTH

15. PLACE OF DEATH

16. DATE OF DEATH

17. PLACE OF BIRTH

18. DATE OF BIRTH

19. PLACE OF DEATH

20. DATE OF DEATH

21. PLACE OF BIRTH

22. DATE OF BIRTH

23. PLACE OF DEATH

24. DATE OF DEATH

25. PLACE OF BIRTH

26. DATE OF BIRTH

27. PLACE OF DEATH

28. DATE OF DEATH

29. PLACE OF BIRTH

30. DATE OF BIRTH

31. PLACE OF DEATH

32. DATE OF DEATH

33. PLACE OF BIRTH

34. DATE OF BIRTH

35. PLACE OF DEATH

36. DATE OF DEATH

37. PLACE OF BIRTH

38. DATE OF BIRTH

39. PLACE OF DEATH

40. DATE OF DEATH

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